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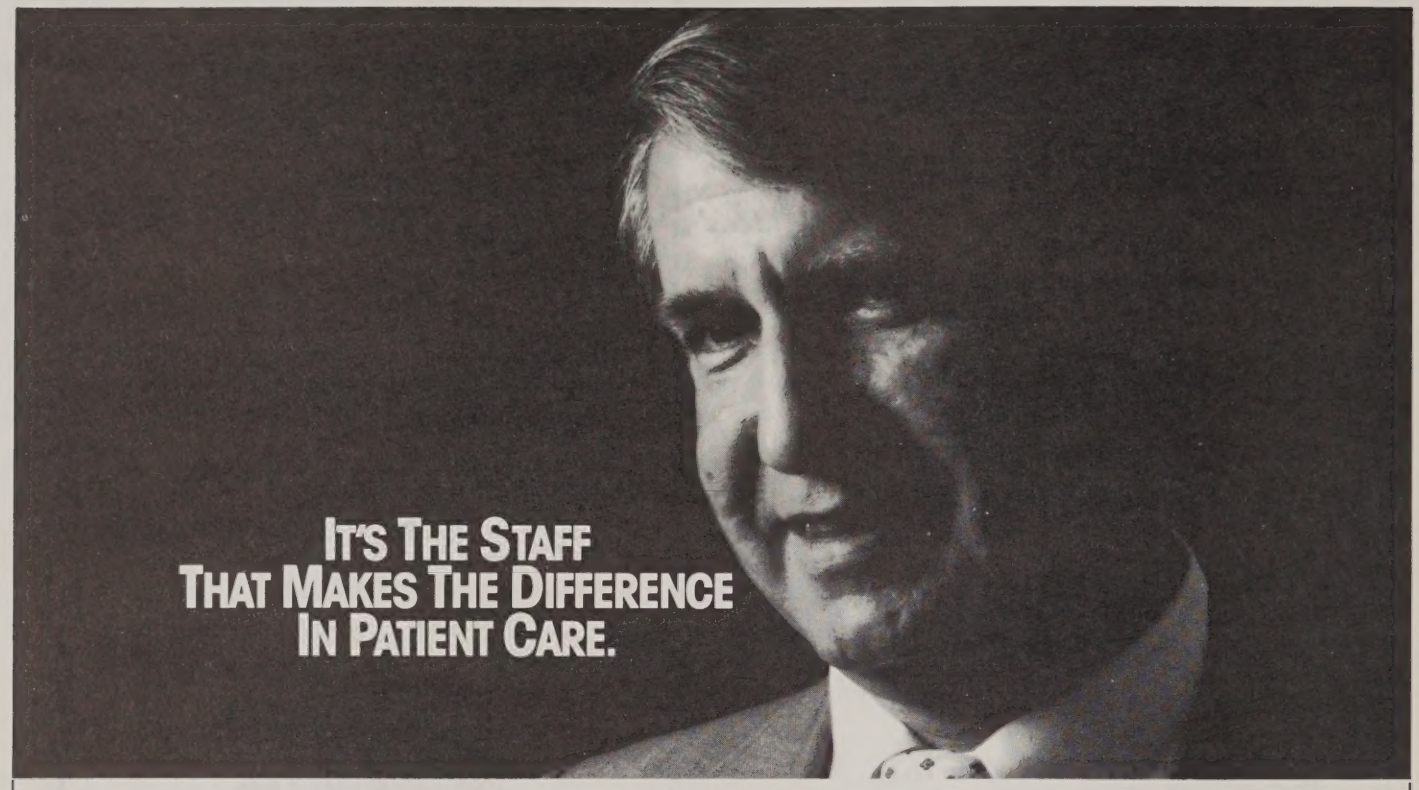

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THE HAMPDEN HIPPOCRAT

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On our cover is Cooley Dickinson Hospital in Northampton, Massachusetts. See related article on page 8 in this issue.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HDMS President's Message

Nancy L. Weiss, M.D., President

I am continuing on my theme of improving our various professional relationships by focusing on two of them; our ralationship to patients and our relationship to lawmakers.

Our patients form an immediate impression of us from our personal and office appearance as well as from our caring manner. This needs to be carried over to the Hampden District Medical Society office. Fortunately, we are blessed with two excellent secretaries who are pleasant and helpful as new community members ask for physician referrals. This can now only be done over the phone since access to our office has become so limited. However, the search committee continues to look for a location near the I-91 axis (easily and safely accessible). No longer will we have free rent, but no longer will our office be inaccessible, inconvenient and possibly unsafe. Our ability to once again have patients deal with our staff face to face will give us the chance to make that important favorable first impression.

Another favorable impression I would like to make is upon our legislators. At times I often think that is impossible but I am not giving up. The two approaches we have set up are first, a series of 7 forums, 1 each month letting us hear the individual gubernational candidates. The details are given elsewhere in this Hippocrat. The second is my personal enthusiasm, an experimental one day mini internship for a legislator to spend an entire day accompaning a physician as she or he make hospital rounds, attends clinics, sees office patients or performs procedures. Patient confidentiality will be maintained and patient permission will be previously obtained. Legislators will not be present during counseling of an intimate nature or if the legislator is personally acquainted with the patient, etc. The amount of energy and time to set this up and coordinate it is enormous but with the help of Kevin Milisky at the Massachusetts Medical Society we should be able to do it well.

The benefit I see from this "internship" is an increased dialogue both in quality and quantity between our members and the legislature. I hope that the rapport developed by this would result in increased access so that the involved physicians can call their "intern" on health matters and have real credibility. Conversely, I hope the "interns" will check with their host physicians when in doubt about the effects of impending legislation on local care. This program will introduce our legislature to the doctor-patient experience, not just to the technical side of medicine. Participating physicians in California say a direct benefit to them is the reminder of their role in society, that Medicine is more than just a job.

I want this program to be a success and expanded to include a number of other community leaders such as business executives, educators, administrators, and the public officials. Programs of this type are successfully in place in Colorado, Oregon and California. April 27, 1990 is the date we've chosen to launch this effort. All of you interested in participating should contact Carol Nystrom at the office. ■

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Committee Highlights

The Executive Committee of Hampden District Medical Society met on January 16, 1990.

The first issue under old business was the report on the search for office space. Dr. Weiss had reported that space at 1111 Elm Street in West Springfield looked very good, but the rent may escalate over the three years of the lease that had been offered. Further exploration into the possibility of purchasing a small home would be entertained and the search will be continued.

The difficulties of a "General Donation Funds" were discussed and a detailed memorandum from Dr. McDermott of the Mass. Medical Society was referred to which outlined the financial and the legal problems of such a fund. Dr. Weiss, however, will continue to work on ways to have a fund like this for Hampden District. Meanwhile, it was felt that Immunization Fund checks should be returned with a covering letter thanking members for their donations.

Under new business the Mass. Medical Society Nominating Committee will be considering the candidacy of Dr. William Callahan of the Franklin District as Vice-President. A motion was made and seconded by the Executive Committee that the Hampden District Medical Society supports this candidacy of Dr. William Callahan.

Dr. Weiss has told Commissioner Cipolla that Hampden District would provide him with lecturers for Public Health Nurses if he would send us a list of topics.

A request by Dr. Sheffield was noted concerning new members for the MMS Student Health and Sports Medicine Committee. (His request is published elsewhere in the Hippocrat.)

A Legislative Intern Program is being set up for April 27, 1990, under the supervision of Ms. Milesky. Physician volunteers for this program are being sought.

Public Relations Committee has announced that a series of meetings with gubernatorial candidates is being established. The first will be at the Deliso Center at Mercy Hospital beginning at 6:00 p.m. on February 27, 1990. Subsequent meetings will be held at a variety of hospitals. Ms. Michael Barnes is lining up a total of 7 candidates for these meetings which will extend into the summer.

Dr. Remsberg's budget for 1990-1991 was approved and the meeting concluded with discussions of the plans for the District Meeting on January 23, 1990.

The Public Health Committee met on January 30, 1990 under the chairmanship of Dr. Riley. The discussion centered on the question of what type of project this committee should consider undertaking for the year 1990. Dr. Barnshaw expressed concern over the volume of substance abuse, particularly drug abuse that has been reported to the committee over the past year, by both the Methadone Clinic Director and the Greater Springfield Alcoholism Services Program. Dr. Sheffield agreed and felt moneys on the federal level should be directed at the education on these topics. Commissioner Cipolla said he would like to see our committee consider ways to help infants born to drug addicted mothers. He said that just a couple of workers concentrating on these mothers would make a great difference in the quality of life for these babies.

Commission Cipolla also went on to point out that there are 1,400 individuals and 750 families that are homeless in 1989 in our area. Currently they are being housed and treated at the Worthington House which can help 120 individuals at 12 shelters across the City. The remainder are found rooms in four motels in the area. At present, Wesson Women's Unit of Baystate Medical Center does offer some help to women with substance abuse problems. In order to obtain more first-hand information on substance abuse infants, the Committee has invited Dr. Edward Bailey of Baystate Medical Center to its February meeting. ■

Terry D. Ryan, M.D.
Co-Editor Hampden Hippocrat

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The Cooley Dickinson Hospital

This is the seventh in a continuing series of articles featuring Western Massachusetts Hospitals

Northampton—The Cooley Dickinson Hospital in Northampton, a 237-bed community hospital serving the Central Pioneer Valley, is undergoing sweeping change designed to better serve more than 115,000 residents of its service area and help physicians in an extremely hostile climate for practicing medicine.

As it enters the 1990's, Cooley Dickinson's top priorities include building upon cooperative relationships with its capable Medical Staff, updating technology, adding new services, and exploring opportunities to lessening the pressure on practicing medicine in Massachusetts.

Craig N. Melin, Hospital President

After experiencing one of the most challenging years in its 104-year history, Cooley Dickinson moved forward in 1989 with the opening of its new 24-bed inpatient Psychiatric Unit, expanding its reach in Emergency Medicine through a sophisticated Advanced Life Support system covering the City of Northampton and surrounding towns, and through the introduction of the Fast Track Emergency Medical Service for the less acutely ill or injured.

The hospital introduced new medical technology throughout the second half of 1989 to improve diagnosis and treatment in areas where Cooley Dickinson is especially strong. For example, the hospital added the latest in Ultrasound imaging with color-doppler capabilituy, a new Mammography suite and Mammography machine with unmatched precision, a new Radiation Therapy Simulator which went on line in January, 1990 and is planning on adding new computer technology to streamline its growing surgical services to improve scheduling and coordination.

An Extraordinarily Qualified Medical Staff

Cooley Dickinson is fortunate to have a highly qualified Medical Staff. 78% of its active medical staff are Board Certified in their specialties or sub-specialties. Cooley Dickinson's level of Board Certification is extremely high in any community hospital setting, compared to the national average of just over 56% Board Certification among physicians.

While hospitals throughout Massachusetts struggle with the exodus of younger practitioners, Cooley Dickinson is enjoying success in attracting physicians to augment its experienced staff of family practitioners, radiologist, surgeons and specialists. 75% of its Medical Staff are under 50-years-old and 43% are under the age of 40-years-old. The Medical Staff's combination of youth and experience poises Cooley Dickinson to deal effectively with the challenges of caring for patients well into the 21st Century.

Turning The Cooley Dickinson Hospital around in 1989

Physicians played a key role in the financial turnaround of The Cooley Dickinson Hospital in 1989. By working with the hospital to increase admissions and lower length-of-stay, the Cooley Dickinson Hospital finished fiscal 1989 as one of only 20% of all Massachusetts hospitals reporting a surplus in this extremely challenging year.

Cooley Dickinson faced growing losses in the first quarter of 1989 and focused its attention on collaborating with physicians to increase admissions and lower length of stay. The result was a turnaround in volume which was 8% off for the first quarter from 1988 to a net increase of .5% for the entire fiscal year by September, 1989. This 8.5% swing over nine months dramatically improved the hospital's viability and was the direct result hospital/physician cooperation.

Balancing high quality patient care and cost control, length-of-stay for inpatients dropped from an average 5.7 days/patient to 5.2 day/patient by the end of the year. Again, this decrease in cost/patient significantly increased Cooley Dickinson's ability to avoid what appeared to be a disastrous scenario for the year. The decline in length-of-stay occurred within a hospital wide effort to improve quality of care through upgrading equipment, maintaining a low patient/nurse ratio, and staff training.

The Medical Staff also played a key role in Cooley Dickinson's ability to achieve rate relief. Physician leadership in several key meetings with payors, legislators, local employers, and the community rallied support for a hospital which is a sole provider in its service area.

Central to the hospital's turnaround was the willingness of the Medical Staff to learn the complexities of health care financing by participating in workshops led by President Craig N. Melin and Vice President for Finance, Deborah Anderst. The relationship between managing patient length-of-stay and admissions within the confines of Chapter 23, current hospital finance legislation, is currently the key to the survival of hospitals.

Helping Physicians Practice Medicine

Cooley Dickinson is working with physicians on several ways the hospital can help its Medical Staff practice medicine in an extremely hostile climate.

For instance, the hospital is in the midst of a Feasibility Study to determine the need for a new Medical Office Building on the campus of Cooley Dickinson. Over the years, physicians expressed an interest in modern medical offices in the hospital or on its campus. Working

with physicians, the need for new space which is cost effective for both independent practices and the hospital is being analyzed.

Another area where physicians find it difficult to manage their costs is in the area of medical malpractice insurance. Cooley Dickinson is working closely with its medical staff and with specialists from the Premier Health Alliance to investigate "off shore" malpractice insurance as a more predictable alternative to the Joint Underwriters Association (JUA) plan now in effect. The hospital anticipates that a predictable, more cost effective plan will be worked out in 1990.

The hospital is working with a Managed Care Task Force comprised of physicians, employees, and financial specialists in establising hospital/managed care contracts which meet the best interests of its Medical Staff while appropriately and cost effectively insure area patients.

In 1989 The Cooley Dickinson Hospital was sponsored by Boston's Beth Israel Hospital as an Affiliate Member in the Premier Health Alliance. The Alliance provides opportunities in group purchasing, physician and staff recruitment and marketing activities to member hospitals. Chief among the opportunities for Cooley Dickinson is sponsored clinical research for physicians who wish to keep their hands in research while practicing medicine.

Cooley Dickinson Hospital regularly alerts its Medical Staff of opportunities to conduct clinical trials or participate in basic medical research. For many physicians, practicing outside of a teaching hospital denies them opportunities to contribute to new medical discoveries. The Premier Alliance programs offer such opportunities.

Identifying Areas of Clinical Expertise

Cooley Dickinson Hospital's reputation as an excellent community hospital has traditionally not been focused in terms of clinical expertise. Due to special strengths within the hospital's medical staff, Cooley Dickinson is working with Task Forces in five key areas where the hospital is especially strong.

These include:

CANCER TREATMENT: As an Accredited Cancer Treatment Center, Cooley Dickinson recently hired an Oncology Social Worker to provide coordination to the hospital's strengths in Oncology inpatient care, treatment including chemotherapy, radiation therapy, and oncology surgery, mamography, and oncology nursing. The hospital recently added a Radiation Therapy Simulator to its Radiation Therapy Department which went on line operationally on Febraury 2, 1990.

ORTHOPEDICS AND SPORTS MEDICINE: Cooley Dickinson Hospital is fortunate to have Hampshire Orthopedics, Inc. practicing practically across the street from the hospital. Hampshire Orthopedic's five surgeons perform more total joint replacements at Cooley Dickinson than at any other community hospital in Western Massachusetts. Together with Hampshire Orthopedics, the hospital is sponsoring a Sports Medicine Conference featuring Dr. H. Royer Collins, former team surgeon to the NFL Cleveland Browns on March 9, 1990 as a significant step in expanding in an area of expertise for Cooley Dickinson.

WOMEN'S HEALTH PROGRAMS: With outstanding medical treatment available in Obstetrics, Gynecology, Mamography, mental health and other women's related issues, Cooley Dickinson is undertaking a review of its services which lend themselves to a focused Women's Health program. Under development are facilities to match the high quality care available for women at the hospital.

PSYCHIATRIC SERVICES: With the opening of its new 24-bed short stay psychiatric service in September, 1989, Cooley Dickinson became the latest entrant into an expanding market for mental health treatment. 1990 is dedicated to gearing its Psychiatric Unit up to handle a full complement of 24 voluntary and involuntary psychiatric patients. Specializing its services to meet community needs is the next phase for Cooley Dickinson with an emphasis today on providing Psychiatric services for young adults.

EMERGENCY MEDICINE AND OUTPATIENT TREATMENT: In 1989, The Cooley Dickinson Hospital took two significant steps in Emergency Medicine to better serve both its acutely ill or injured patients and those with non-life-threatening ailments. The first was the establishment of the Fast Track Emergency Medicine Program for those with less acute injuries and illnesses. This service provides extended coverage for eight hours per day to deal with less serious medical emergencies. The Fast Track program decreased the wait for patients from just under two hours to less than 45 minutes. The other achievement was establising the Advances Life Support Ambulance service with the City of Northampton with emphasis on pre-hospital ALS response not only within the city but throughout the region in support of local Basic Life Support responders.

Matching its Facilities to the Quality of Patient Care

The Cooley Dickinson Hospital is poised to move one step closer to upgrading its facilities through a capital improvement project featuring a new patient care wing. One of the weaknesses of the hospital's facility is its aging patient care and ancillary services buildings. The hospital's overall facilities plan calls for a new maternity Unit, new Respiratory Therapy Space and new configuration for the hospital's Social Service, Admitting, Patient Financial Counselling, and new Front Entrance next to its current Emergency Entrance.

The longer term calls for several smaller projects to upgrade its laboratory, a new Pediatrics Unit, new Medical Office Space and in-hospital physician's lounge, and renovation of the hospital's Medical/Surgical Floors.

Conclusion

The Cooley Dickinson Hospital is moving forward on several fronts at once as it attempts to build on 104 years of tradition while growing to meet the demands of a rapidly changing environment. Key to Cooley Dickinson's success will be its ability to help physicians find ways to make it easier to practice medicine in an extraordinarily hostile environment.

Physicians are being buffeted by regulatory change, unpredictable and astronomical costs in Medical Malpractice Insurance and a more skeptical public and private sector. Cooley Dickinson is seeking to address the challenges physicians face in such a way that confidence in the hospital and its Medical Staff can grow together. ■

Hampden District Meeting

The Winter meeting of the Hampden District Medical Society was held on Tuesday, January 23, 1990 at the Sheraton West and was well attended with 90 members and guests present.

There was an active Business Meeting which was followed by the annual presentation by the President Elect of the AMA: this year it being Dr. C. John Tupper.

After approval of the minutes of the last meeting, Dr. Bruce Stoler reported on the closing of the Library at the Academy of Medicine which was scheduled for April 1, 1990. There has been some difficulty in disposing of books, and thus the closing of the library is not progressing as rapidly as was hoped.

The Continuing Medical Education Credit Program at the Providence Hospital held its last program in December, 1989.

The Springfield Academy of Medicine Lectureship will be set up through the Baystate Medical Center and the Springfield Science Museum, however Baystate requires that the Lectureship be endowed. The Dr. John Maloney books and money will go to Mercy Hospital. The Municipal Hospital has asked for the library space as of January, 1991.

C. John Tupper, M.D. president-elect AMA.

Dr. John Remsberg, our Treasurer, then presented the 1990-1991 Budget. There will be no dues increase, but the members will be asked to continue their voluntary payment of the dinners at district meetings to help defray expenses. The budget was subsequently approved.

Our president, Dr. Nancy Weiss, told the members that office space in Springfield and West Springfield is being explored for a new Hampden office. Also being considered is the purchase of a small house in a commercial area. There is no plan to move immediately and, thus, there is time to explore all of these options. After some discussion, membership generally felt that the Society should move whenever a reasonable opportunity presents itself.

Dr. Weiss announced that a legislative intern program is being considered. This apparently has been very successful in Colorado. The date for the program will be Friday, April 27, 1990, and permission for the program is now being sought from hospitals and nursing homes in the area. Dr. Weiss asked interested physicians to call the Society's office.

There was some discussion of the General Donation Fund and Bereavement Counselling Program.

Dr. Mark Mullan then presented a State Legislative Update. Dr. Mullan felt it was a good year in terms of getting legislation passed for the Mass. Medical Society. One of the top priorities for the Medical Society was an ammendment which would move disciplinary hearings from the Board of Medicine to the Division of Administrative Law Appeals. This change will provide hearing officers who are independent of the Medicine Board and will help ensure impartiality.

There were two announcements at the end of the meeting. The first of which reminded the membership that we are looking for a new editor for the Hippocrat and an announcement from Dr. Alonzo Sheffield requesting any interested physicians to contact the Society's office if they wish to work on the MMS Committee on Student Health and Sports Medicine. A notice describing the change in the Hippocrat editorship is in last month's Hippocrat and a notice concerning Dr. Sheffield's announcement is in this month's Hippocrat.

Following the social hour and dinner Dr. Weiss introduced Dr. C. John Tupper, President-Elect of the American Medical Association. Dr. Tupper gave a detailed description of resource based relative value schedules which are being prepared by Congress and the circuitous route through which they have been formed. After delivering this requested dissertation, Dr. Tupper then took a few minutes to remind physicians of their social responsibilities. Dr. Tupper's remarks were well received and the meeting adjourned at 10:00 p.m. ■

Terry D. Ryan, M.D.,
Co-Editor Hampden Hippocrat

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Health Care for the Homeless

Every night of the year Springfield is "home" to as many as 1500 homeless families and individuals. Every day the numbers grow. At one time the homeless, or street population, were primarily males with an average age of 50. This is no longer the case. Homelessness, today, includes newborn infants and elderly. Lack of affordable housing is now the leading cause of homelessness and is reaching new heights in the City of Springfield. This population faces a host of problems.

Many are malnourished, have poor dentition, suffer chronic illnesses, and due to the many stress factors in their lives, are more prone to acute illnesses. Besides an inordinate number of HIV positive patients, we find a great number of people with cancer, seizure disorders, COPD, peripheral vascular disorders, asthma, hypertension, TB and chronic gastrointestinal problems. Among the acute medical problems are URI (especially among children), trauma due to street life, extensive foot problems (again due to life style), genitourinary problems and venereal diseases. Added to this may be the ilnesses of substance abuse and/or mental illness, which greatly affects the compliancy of patients with needed treatment regimens. How do we meet their needs?

Health Care for the Homeless has been in existence since 1983. Its "first office" was a station wagon from which Sr. Julie Crane, Sisters of Providence, driving from shelter to shelter provided health care to the homeless of Springfield. The local soup kitchen eventually provided space for an office and another nurse joined forces with Sr. Julie.

Now, Health Care for the Homeless, a Department of Mercy Hospital, consists of six registered nurses and is augmented by volunteer physicians, medical residents and nursing students. We provide medical care to clients at nine shelters, two soup kitchens, motels housing homeless families, and various other sites where homeless people congregate. This care is available five days a week, nine-ten hours per day, to all the previously mentioned locations at specified hours so that clients will know when to expect the nurses and/or physicians.

Working under a nursing model, the program consists of three major components: 1) primary care, under physician directed protocols; 2) referral to physicians, Emergency Rooms and other community agencies; and, 3) healthcare education, through programs conducted on a regular schedule at various shelters.

Referrals for primary/emergency care are received by Mercy Hospital Emergency Room and a number of physicians. Surgical problems are handled by Dr. Marshall Jordan, who not only accepts our patients, but comes to the shelters to see patients as needed. Dr. Eugene Boss sees patients every Wednesday at the Worthington House office. Those in need of medical care are referred there by the nurses. In many cases, it is also the nurse who provides transportation.

Dr. Shebar, a Mercy Hospital Emergency Room physician, acts as our Medical Director and is responsible for medical direction, such as updating nursing protocols and acting as a medical resource for the nurses.

Medical/Pediatric residents from Baystate Medical Center are present on Friday mornings at one of our four family shelters. The main goal is to offer physical exams to children who are either new to the area and/or have no pediatrician. In the past, children have been refused admittance to local schools until they were able to have a physical and innoculation update. This is no longer the case, as they are now referred by this program into the medical system for on-going care.

All nurses are responsible for assessment, intervention and planning care according to approved protocols. These protocols range from care of wounds, performing basic (non-invasive) lab work, treatment of minor illnesses, URI's, foot problems, etc. We also carry out TB screenings and run Flu clinics, and coordinate care with other health care agencies.

continued

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Health Care for the Homeless continued

For instance, in October of 1989, three patients from one of our shelters were diagnosed as having Hepatitis A. As the initial case had been a food handler, we realized that there was potential for massive outbreak. Over a two day period we drew Hepatitis screens and gave ImG to 51 clients. A total of seven cases developed and these were followed. Some existing conditions at the shelter were corrected and new rules put into effect in the kitchen.

In 1989 health care was provided to 1133 individual clients through 5643 medical encounters at various shelters; 1074 referrals were made to outside agencies; 49 educational classes were held and 440 individual client interagency case conferences were conducted.

We have been very fortunate in enrolling the assistance of many physicians willing to take our patients on referral. Most specialities are covered. However, we have a constant need to add to the list of referral physicians in all areas. Because our clients have received little or no preventative dental care, hardly a week goes by without at least one or two dental emergencies. Therefore, it does not take long to exhaust a list of available dentists.

While it is obvious that the number of HIV positive patients continue to rise among the general population, the number among our population is rising at an alarming rate. This is not surprising due to the recognized incidence of drug abuse among a certain segment of the homeless population.

Securing medical referrals for on-going care is a problem. We have few medical resources, and if a patient is in end-stages of AIDS, we may get him/her into a hospice setting. However, placement for supportive care during the illness is nonexistent, except in an acute in-house short-term hospital setting.

Although our goal of bringing health care to those who need and seek it is being realized, their needs still remain great. Among this population substance abuse and mental illness is disproportionately high.

Many carry a dual diagnosis and fall between the cracks in a system which traditionally deals with one diagnosis or the other. Detox beds and rehabilitation programs are not sufficent. Services for the mentally ill are lacking. Budget cuts in our area have left agencies dealing with these segments of our population understaffed and "beds" have been eliminated in treatment facilities. Human services have been hard-hit by the present economic crisis. And, it is well to remember that it is often said, "a society is known by the care of its weakest members." We try not only to respond to their needs, but to provide holistic health care, while recognizing human dignity. ■

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Student Health & Sports Medicine

Dr. Alonzo Sheffield is a member of the Student Health & Sports Medicine Committee of the Massachusetts Medical Society. He has been asked by Dr. Frederick Whoriskey who is Chairman of this Committee, to see if there are any other physicians from Western Mass. who might be interested in working on this Committee.

The Committee meets approximately quarterly from 11:00 a.m. until 1:00 p.m. with lunch being served. The meetings are held at the Mass. Medical Society Office in Waltham. However, consideration is being given to holding some of the meetings in Western Massachusetts.

This Committee discussed current issues affecting student health and sports medicine, with some of the current topics being considered being:

1. Steroid usage among secondary students as well as college students.
2. Methods of getting the school boards and communities to support growth and development, not demagogically listed as "sex education".
3. Usage of condoms which has been very explosive with reference to AIDS.
4. Physician nurse relationships in secondary schools.
5. Positions that the Committee recommends that the Mass. Medical Society should take in regards to current issues with reference to the scope of the Committee. The recommendations of the Committee are then submitted to the governing bodies of the Mass. Medical Society for consideration.

If any physicians from Western Mass. have an interest in being on this important committee, please drop Dr. Whoriskey a note at the following address:

Frederick G. Whoriskey, M.D.
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Generic Drugs: Good for All, Good for Some or Good for Nothing?

Nancy S. Jordan, Pharm. D.
Director, Drug Information Services
Holyoke Hospital, Holyoke, MA

Scott L. Traub, Pharm. D.
Director, Clinical Pharmacology
Mercy Hospital, Springfield, MA

Michael Masamitsu, Pharm. D.
Assoc. Director, Clinical Pharm. Services
Baystate Medical Center, Springfield, MA

Generic Drugs: are they the best things for consumers since the advent of warehouse grocery stores or are they substandard versions of brand name drugs manufactured by "bathtub" generic firms? Generic drugs now account for 40% fo all prescriptions written for drugs that are available from competing manufacturers, and account for 25% of all prescriptions. One thing is certain, the sharp increase in the numbers of generic drugs in the past few years have been a source of confusion for patients and physicians alike. The revelations of bribes to FDA officials by generic drug manufacturers and other questionable activities has cast further doubts upon the reliability of generic drugs.

In order to present our views as hospital-based clinical pharmacists regarding generic drugs, terms that will be used extensively in the succeeding paragraphs must be defined, and some historical background of drug marketing and development must be reviewed.

Definitions

NDA—new drug application requesting FDA approval to market a new drug for human use.

ANDA (abbreviated NDA)—simplified submission permitted for a duplicate of an already approved drug. Includes all information on chemistry and manufacturing controls found in NDA, plus bioequivalency tests demonstrating equivalence to innovator drug. Does not require duplication of animal and human safety and efficacy testing.

Bioavailabilty—rate and extent of drug absorption.

Bioequivalence—scientific basis on which generic and innovator drugs are compared. Generic drugs must be bioequivalent, to a degree, calculated statistically, so that products evaluated as therapeutically equivalent can be expected to have equivalent therapeutic effects.

Drug Development and Marketing

In 1938 the Food, Drug and Cosmetic Act was passed. Drugs had to be reviewed for safety before they were marketed. Following the cases of thalidomide—induced congenital deformities, the Kefauver-Harris amendment to the Act was added in 1962. Drugs had to be shown to be safe AND effective.

At the present time, it takes about 8 years and millions of dollars for a drug to be synthesized, go through the required testing, and finally be approved by the FDA for marketing. Patent protection normally lasts 17 years. Half of the patent protection is gone before the drug is even marketed.

When patent protection expired for a pre-1962 brand name drug (innovator drug) a generic manufacturer could submit an abbreviated new drug application (ANDA). While a new drug application (NDA) requires information on the chemistry of the drug, manufacturing controls, and safety and efficacy information, an ANDA does not require data from the manufacturer on safety and efficacy—this has already been established in the NDA and is a needless duplication of animal and human testing. For a generic drug to be approved, the ANDA plus information on bioequivalence to the innovator drug was required. Until 1984, there was no similar mechanism for drugs marketed after 1962—so few generic drugs were available. The time and expense requried to duplicate safety and efficacy studies was prohibitive.

In 1984, the Drug Price Competition and Patent Restoration Act was passed. The 1984 Act allowed generic manufacturers of drugs first marketed after 1962 to submit an ANDA plus bioequivalency data. This made it much less expensive for a manufacturer to develop and market a generic drug. Additionally, the Act extends patent protection for up to an additional five years for innovator drugs.

According to the 1984 Act, all approved generic drugs must fulfill 5 characteristics: (1) have the same active ingredients as the innovator drugs; (2) be identical in strength, dosage form (tablet, capsule, suspension, etc.) and route of administration to the innovator drug; (3) be generally used for the same illnesses, with the same precautions, and warnings on the label; (4) be bioequivalent; (5) be manufactured according to the FDA's standards for good manufacturing practice.

Patents for many of the popular innovator products have recently expired and with the 1984 Act, many generic manufacturers have produced these drugs. Generic drugs are less expensive for the pharmacist to purchase and these savings, at least to some extent, are generally passed on to the patient.

Methods Used to Determine Bioequivalence

An FDA—appointed task force concluded that bioequivalence testing is an excellent predictor of clinical performance (or therapeutic equivalency). If the rate and extent of release of active ingredient are comparable, the two products are considered bioequivalent.

For some older drugs, in vitro studies examining the rate of dissolution and disintegration of the dosage form are required.

For most oral medication, in vivo tests of bioavailability are required. Bioavailability tests are generally performed as single

dose randomized studies using a crossover design. When an in vivo bioavailabilty study is performed, the area under the concentration-time curve (AUC), the maximum concentration attained (Cmax), and the time Cmax was attained (Tmax) are measured. Studies must have statistical power of 80% to detect a difference of at least ±20%. Requirements differ for some drugs. Differences can't exceed ±10% for warfarin, ±25% for anti-arrhythmics, and ±30% for antipsychotics.

A common misconception is that generic drugs are often made by "bathtub" operations while innovator drugs are made in modern facilities. In fact, in most instances, generic firms have modern, state-of-the-art equipment and plants that compare favorably to or even surpass those of innovator firms. Actually, innovator companies manufacture 70-80% of the generic drugs sold. The rate of defects found by the FDA is low in both sectors. After the publicity regarding bribe-taking by FDA officials, the FDA analyzed numerous samples of the 30 most-prescribed generic drugs (representing 70-80% of all generic drugs prescribed nationwide). Only 1.1% of the samples did not conform to standards, a compliance rate which is typical of the drug industry as a whole. Innovator companies also occasionally distribute substandard products. On September 13, 1989 (the day the Wall Street Journal carried the story of the "Generic Drug Scandal"), the Journal also printed an article concerning Eli Lilly halting distribution of all drugs made at its Indianapolis plant with recalls of 10 drugs because FDA inspectors found "objectionable conditions" in nearly every area inspected.

While FDA requirements allow up to a 20% difference in bioavailability between differing formulations of a drug, the average difference in AUC is about 3.5%. In fact, 80% of the generic drugs approved by the FDA in the first two years after the 1984 Act had AUC ±5% of the innovator drug. These are very small differences. To put this into perspective, the US Pharmacopeia (official Compendium of Drug Standards) requires that drugs not differ from their stated potency by more than ±10%, and that drug potency may not vary among dosage units by more than ±15%. This means that the potency differences between lots of the same drug made by the same manufacturer may differ by 20%. Something else physicians should appreciate is that the formulation of an innovator drug that is tested for safety and efficacy (for an NDA) is often not the same formulation that is approved for clinical marketing. In these situations the innovator company must show bioequivalence to the original formulation by the same methods used by the generic manufacturers.

Partenteral drugs (IV, IM) are, by the nature of their method of administration, 100% bioavailable. Issues of bioequivalence are relevant for orally administered medications. Under the guidelines adapted with the 1984 Act, no drugs approved since passage of the 1984 Act have been shown to be therapeutically inequivalent. A well publicized case report of primidone inequivalence has since been called into question both by the FDA, who subsequently investigated the report, and also by the editors of the Journal in which the report was published.

continued

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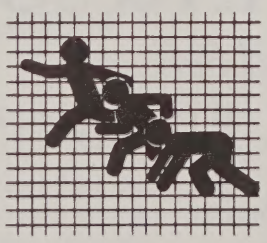

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Generic Drugs: Good for All, Good for Some or Good for Nothing? continued

However, cases of therapeutic inequivalence may go undetected. Alterations in a patient's response to a medication may be suspected to result from changes in disease process rather than changes in the medication.

Problems with Bioequivalency Studies

Bioequivalency testing is a developing science. Which pharmacokinetic parameters (AUC, Cmax, Tmax) correlate best with bioequivalence? The answer is not yet known. Bioavailability can be affected by factors other than those relating to product formulation such as GI motility, gastric pH, concomitant diseases, and concomitant medications, liver function and liver blood flow. How metabolically active metabolites should be analyzed is not yet established. Lastly, extrapolating from single dose studies to multidose administration may not be totally accurate.

The American Academy of Family practitioners recently approved a policy statement opposing mandatory substitution of generic drugs. Professional pharmacy groups such as the American Society of Hospital Pharmacists have criticized the AAFP's action by stating that "drug product selection should be based on objective scientific data and individual patient-specific criteria. The AAFP's criteria... are not scientifically based".

Questions regarding bioequivalency issues should not cause us to abandon use of generic drugs. Antibiotic susceptibility testing is not a perfect science either. Filter paper discs impregnated with antibiotic are placed on an agar dish inoculated with micro-organism. The zone of growth inhibition surrounding the disk is correlated to a minimal inhibitory concentration determined in a cell-free, protein-free media which is in turn related to in vivo antimicrobial activity. Every day we base our therapy of infectious diseases upon the results of such susceptibility testing. Yet this testing also does not take into account the numerous patient factors that can affect the success or failure of therapy.

Practical Considerations for the Prescribing Physician.

What practical suggestions do we offer?

1. While generic drugs are identical in active ingredients, inactive ingredients (excipients, binders, coloring, taste and appearance) may differ. If this is an important consideration for a patient, either the innovator drug or drug from the same generic company should be dispensed with every refill.
2. In patients receiving drugs of low therapeutic index who have been difficult to titrate to an appropriate dose, continually using the same product can be considered. Warfarin, phenytoin, digoxin, thwophylline products, antiarrhythmics and anti-depressants are examples of drugs that fit into this category.

Massachusetts has a positive formulary. Pharmacists are mandated to substitute a generic drug for an innovator drug as long as (a) the medication is on the approved formulary list; (b) the substituted product is less costly than the innovator drug; (c) the physician does not specify "Do Not Substitute" on the prescription. If a pharmacist interchanges a generic drug for an innovator drug, the interchange must be so designated on the label. Additionally, the prescription label must contain the initials of the pharmacist filling the prescription. If you ever have questions regarding what medication(s) your patient has been given by the pharmacist, check the label, and, if necessary, contact the dispensing pharmacist.■

Selected References:
1. Strom BL. Generic drug substituition revisited. N Engl J Med 1987; 316: 1456-62.
2. Nightingale SL and Morrison JC. Generic drugs and the prescribing physician. JAMA 1987; 258: 1200-4.
3. Generic Drugs. Medical Letter 1986; 28:1-2
4. New Drug Development in the United States. FDA Consumer 1988 (Jan.)
5. Wyllie E. Pippenger CE, and Rothner AD. Increased seizure frequency with generic primidone. JAMA 1987; 258:1216-7.
6. Rennie D. Editors and auditors, JAMA 1989; 261:2543-5.

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Continuing Education Courses in Western Massachusetts March-April, 1990

The following is a partial list of Continuing Medical Education Courses that will be offered during March and April, 1990 in our region. The information was solicited from the hospitals and other sponsoring organizations. They were told that we particularly wanted to publicize the visit of scholars from outside institutions to our region. We are planning to make this list a regular feature of the Hippocrat.

MARCH

DATE: Saturday, March 3, 1990, 7:30 a.m.
TOPIC: Legal and Ethical Considerations in Medicine
LOCATION: Quality Inn, 296 Burnett Road, Chicopee, Exit 6 off Mass. Pike
CREDITS: 5 Category I/Risk Management Credits
FEE: $60
INFORMATION: Berkshire Medical Center 413-447-2417

DATE: Saturday, March 3. 1990, 9:00 a.m.
TOPIC: Duodenal Ulcer: An Update/Wallace Ritchie, Chairman, Temple University.
LOCATION: Surgical Grand Rounds, Baystate Medical Center, Springfield
CREDITS: 2 Category I
FEE: Free
INFORMATION: Dept. of Surgery, Baystate 413-784-3466

DATE: Tuesday, March 6, 1990, 9:00 a.m.-12:30 p.m.
TOPIC: Emergency Medicine/Alasdair Conn, MGH
LOCATION: Clark House, North Adams Regional Hospital
CREDITS: 3 Category I
FEE: Free
INFORMATION: Darlene Demo 413-663-3701 ext. 179

DATE: Friday, March 9 through Saturday, March 10, 1990, 9:00 a.m.
TOPIC: Reproductive Loss
LOCATION: Sheraton Tara, Springfield
CREDITS; 14 Category I
FEE: $250
INFORMATION: Baystate 413-784-3466

DATE: Monday, March 12, 1990, 6:30 p.m.
TOPIC: Use of Anticoagulants in CVA
LOCATION: Providence Hospital, Holyoke
FEE: Free
INFORMATION: Dr. Gulab Shah, 413-536-5111

DATE: Tuesday, March 13, 1990, 11:00 a.m.
TOPIC: Topics in Pediatric Rheumatology/ Lawrence Zemel Newington Children's
LOCATION: North Adams Regional Hosp., No. Adams
FEE: Free
CREDITS: 1 Category I
INFORMATION: Darlene Demo, 413-663-3701 ext. 179

DATE: Thursday, March 15 & Friday, March 16, 1990, 7:30 a.m.
TOPIC: Advanced Trauma Life Support
LOCATION: Wesson Memorial Bldg., Baystate, Spfld.
FEE: $450
CREDITS: 14 Category I
INFORMATION: 413-784-3466

DATE: Friday, March 16, 1990
TOPIC: Innovative Strategies in Health Education
LOCATION: MMS Hqtrs., 1440 Main St., Waltham
FEE: $40
INFORMATION: New England Health Education Assc., P.O. Box 142, Winthrop, ME 04364.

DATE: Saturday, March 17, 1990, 9:00 a.m.
TOPIC: Regression of Atherosclerosis by Intravenous Substrates/Stanley Dudrick, Chairman, Pa. Hosp.
LOCATION: Surgical Grand Rounds, Baystate Medical Center, Spfd.
CREDITS: 2 Category I
FEE: Free
INFORMATION: 413-784-3466

DATE: Wednesday, March 21, 1990, 3:00-9:00 p.m.
TOPIC: Risk Management: Physician—Patient Communication
LOCATION: Northampton Hilton Hotel
CREDITS: 5 Category I
FEE: $125 for MMS members, staff of Mercy or Baystate; $175 others
INFORMATION: 413-784-3466

continued

Continuing Education Courses in Western Massachusetts March-April, 1990 continued

DATE: Thursday, March 22, 1990, 12:00 noon-6:00 p.m.
TOPIC: Risk Management
LOCATION: Boston Vista Waltham, Waltham
CREDITS: 5 Category I/Risk Management
FEE: $125 MMS members, $175 others
INFORMATION: MMS 1-800-322-2303

DATE: Thursday, March 22, 1990 1:00-5:00 p.m.
TOPIC: Annual Oncology Seminar
LOCATION: Springfield Marriott Hotel
CREDITS: 3 Category I
FEE: $45
INFORMATION: 413-784-3466

DATE: Friday, March 23, 1990 8:00 a.m.-5:00 p.m.
TOPIC: Annual Cytopathology Seminar
LOCATION: Springfield Marriott Hotel
CREDITS: 6 Category I
FEE: $75
INFORMATION: 413-784-3466

DATE: Tuesday, March 27, 1990 8:00 a.m.-4:30 p.m.
TOPIC: Diagnosis and Non-Operative Treatment of Sports Injuries
LOCATION: Springfield Marriott Hotel
CREDITS; 6 Category I
FEE: $95
INFORMATION: 413-784-3466

DATE: Tuesday, March 27, 1990
TOPIC: Repeat Hospitalization for the Ex-Preemie/Perlman Bronchial Pulmonary Dysplasia Berkshire
LOCATION: Clark House, North Adams Regional Hospital
CREDITS 1 Category I
FEE: Free
INFORMATION: Darlene Demo, 413-663-3701 ext. 179

DATE: Tuesday, March 27, 1990
TOPIC: The Process of Litigation: a Case Presentation
LOCATION: Clark House, North Adams Regional Hospital
CREDITS: 3 Category I
FEE: Free
INFORMATION: Darlene Demo, 413-663-3701 ext. 179

DATE: Tuesday, March 27-31, 1990
TOPIC: Practice Managment Series: What Every Physician Needs To Know About Managed Care Contracts; The Business Side of Medicine; How To Prepare For Retirement; Medical Career Options—Joining A Practice or Solo Practice
LOCATION: MMS Hqtrs., 1440 Main St., Waltham
CREDITS: TBA
FEE: TBA
INFORMATION: MMS 1-800-322-2303

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DATE: Wednesday, March 28, 1990 8:30 a.m.-3:30 p.m.
TOPIC: Geriatric Medicine Symposium
LOCATION: Springfield Marriott Hotel
CREDITS: 5 Category I
FEE: $95
INFORMATION: 413-784-3466

DATE: Saturday, March 31, 1990 9:00 a.m.
TOPIC: Resistance to Peritonitis/Allan Dumont, NYU
LOCATION: Surgical Grand Rounds, Baystate
CREDITS: 2 Category I
FEE: Free
INFORMATION: 413-784-3466

DATE: Wednesday, April 4, 1990, 8:00 a.m.-4:15 p.m.
TOPIC: Contemporary Topics in Fever and Antibiotics
LOCATION: Sheraton Tara Hotel, Spfld.
CREDITS: 6 Category I (1 credit in risk management)
FEE: $70
INFORMATION: 413-784-3466

DATE: Tuesday, April 3, 1990, 9:00 a.m.-12:30 p.m.
TOPIC: Antibiotic Selection/Terence Dermody, Harvard
LOCATION: Clark House, North Adams Regional Hospital
CREDITS: 3 Category I
FEE: Free
INFORMATION: Darlene Demon 413-663-3701 ext. 179

DATE: Thursday April 5, 1990 8:00 a.m.-3:45 p.m.
TOPIC: Victim Rights Seminar, Crisis and Crime Treatment and Solutions
LOCATION: Springfield Marriott Hotel
CREDITS 6 Category I
FEE: $65
INFORMATION: 413-784-3466

DATE: Friday, April 6, 1990 8:00 a.m.-3:15 p.m.
TOPIC: Prevention of Coronary Disease
LOCATION: Sheraton Tara Hotel, Springfield
CREDITS: 6 Category I
FEE: $75
INFORMATION: 413-784-3466

DATE: Monday, April 9, 1990, 6:30 p.m.
TOPIC: Epilepsy
LOCATION: Providence Hospital, Holyoke
CREDITS: 1 Category
FEE: Free
INFORMATION: Dr. Gulab Shah

DATE: Saturday, April 7, 1990 9:00 a.m.-5:00 p.m.; Sunday, April 8, 1990 9:00 a.m.-1:00 p.m.
TOPIC: Will Women Lead Medicine in the Nineties
LOCATION: Dedham Hilton, Dedham
CREDITS: TBA
FEE: TBA
INFORMATION: MMS 617-893-4610 ext. 1342

DATE: Saturday, April 21, 1990 9:00 a.m.
TOPIC: Experimental and Pharmacological Management of Cutaneous Extremity Melanoma/Kirby Bland, Gainesville
LOCATION: Surgical Grand Rounds, Baystate, Spfld.
CREDITS: 2 Category I
FEE: Free
INFORMATION: 413-784-3466

DATE: Tuesday, April 24, 1990 11:00 a.m.
TOPIC: Malpractice Avoidance Through Effective Physician-Patient Communication
LOCATION: Clark House, North Adams Regional Hospital
CREDITS: 1 Category I Risk Management
FEE: Free
INFORMATION: Darlene Demo 413-663-3701 ext. 179

DATE: Saturday April 28, 1990 9:00 a.m.
TOPIC: Endoscopy in Cardiovascular Surgery
LOCATION: Surgical Grand Rounds, Baystate Spfld.
CREDITS: 2 Category I
FEE: Free
INFORMATION: 413-784-3466

DATE: Tuesday, May 1, 1990 8:00 a.m.-4:30 p.m.
TOPIC: When Death Meets the Family: Being There for the Dying and Ourselves/Rabbi Kushner "When Bad Things Happen to Good People" and others
LOCATION: Springfield Marriott Hotel
CREDITS: 6 Category I
FEE: $85
INFORMATION: 413-784-3466

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Regional Column

Health Care in the Nineties: New Directions, Hard Choices was the focus of a recent symposium held at American International College. Over the course of two weeks, thirty five undergraduate and graduate students explored the status of the United States health care system, how it has evolved to its present condition, and what the prognosis is for the future.

The symposium, coordinated by Professors Mark Hagopian and Henry Barton, was a thought provoking experience. Twenty-three speakers were recruited from virtually all segments of the health care industry. Authorities from government, academia, medicine and the health care and insurance industries examined the present and future situation.

Three issues pervaded each of the sumposium sessions, the first being why our present health care system is in such a state of disarray. Changing demographics, manpower shortages, and expanded consumer expectations were discussed. Liability issues, advanced technology, and onerous government regulations were also suggested. The AIDS and drug epidemics and an estimated thirty-seven million uninsured Americans were also considered contributing factors.

The second issue examined during the symposium was financing. Health care expenditures have exceeded eleven percent of our gross national product. As this continues to rise, at a rate far above the consumer price index, one government official stated that a battle over who pays for health care is imminent.

As a means of addressing rising expenditures, alternative delivery systems, as in Canada and England were considered. A proponent of National Health Insurance expressed his support for a centralized, government run body which would significantly decrease administrative and bureaucratic costs, allowing for universal access to care.

Others spoke against National Health Insurance, claiming that it would stifle technology and that it does not specifically address the contributing factors to rising health care costs. Smaller, less radical changes in our current system were suggested, such as expansions in existing entitlement programs and mandated health insurance in the work place.

The third issue addressed by the symposium was one of ethical dilemmas. Advances in technology have forced us to consider whether sustaining all lives regardless of cost is logical. If resources are limited, it was asked, should they be allocated for a few, as with transplant programs, or should they be apportioned to many, in the form of preventive programs?

Rationing is an emotional and very controversial topic. While it was explained that the United States currently does not have a policy concerning rationing, it was stated that rationing occurs, based on one's ability to pay for care.

Justice, it was said, must be factored into ethical decisions. Currently choices are made between the patient and the physician. The frontier of the nineties will be to factor economic and social policy concerns into that formula.

Many contrasting opinions were shared by all of the presenters. No one had an easy answer, at times there was not even concurrence on the nature of the problem. Do we spend too much on health care, or too little? What is the "correct" amount? Should all citizens be entitled to basic medical care, and for that matter, what constitutes basic medical care?

Some predict that the existing health care system will not survive. Others suggest instead that the present troubles can and will be surmounted. Cooperation is needed from all sectors of society, consumers, providers, government, business and insurers, to find solutions to these difficult dilemmas. ■

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An Interview with Brian Akers, M.D., Law Student

Brian Akers is a former internist who practiced in South Hadley from September 1978 until June 1988. He left the area at that time to begin an entirely new career. He entered the Stanford University Law School in Palo Alto, California in September 1988. He is now half way through his studies there.

Brian had completed his undergraduate degree in 1971 at Kenyon College. He graduated from the Tufts University School of Medicine in 1975. He was a resident in Internal Medicine at Baystate Medical Center from 1975 until June, 1978. Shortly after completing his residency, he opened a practice of internal medicine with David Clinton, who was a fellow resident at Baystate.

I recently interviewed Brian to find out why he left the practice of medicine and what his thoughts are now as he moves along towards a second career.

Q: When did you begin to think that you might make a change in what you were doing?

A: I took a night school course in literature in 1984. I didn't realize how much I enjoyed writing—not the kind of writing we have to do in medicine—but writing writing, literary and critical writing. I was then lucky enough to get the opportunity to write for a local paper. Even though my writing was atrocious, it was really stimulating for me. I could tell that my life was going to change and either I was going to add something on top of medicine or I would have to have the guts to make a complete break.

Q: And how did you get from that point to law?

A: Little tiny steps. I took another course at UMass in the sociology of law that included reading several cases and some discussions of legal theory. The guy who taught the course became my patient and is still my friend. He was one of those formative people.

Q: So is he a lawyer?

A: He's an anarchist, a true anarchist. He really believes in the writings of Krepotkin and others. He feels that throughout the world the system that we consider to be law is corrupt and corrupting. He really whet my appetite for all of this.

I wrote away to some law schools in 1985. I got the basics of it. In 1986, I took the Law School Admission Test and I did better than I deserved. The next thing I knew I had applied to several schools. I applied to only pretty amazing places. I thought the easy way to deal with this was to apply to places like Harvard, get shot down and, you know, you feel good about yourself. It didn't work out that way. Harvard did shoot me down, and Yale. But Stanford and everywhere else said, "Please come."

I came to see the Stanford campus and I just knew. I saw the campus and I realized these people had made me an offer to join their community. It was hard not to take that seriously.

Q: What do you feel that you've had to give up to have this?

A: A fair amount of money. I was lucky in my practice and I had a good partner. I went from receiving a very privileged income to being unemployed by my own choice. The number one thing I had to give up was my friends. Three thousand miles of distance is a major barrier. I left behind thousands of patients who had become part of an extended family. I'll probably never have anything like the extended family that a medical practice represents again. I left New England, a part of the world I feel physically very comfortable with.

Q: Marshall MacLuhan had a concept of the "content" of one's day. In that sense how has your life changed?

A: I think people in medicine become action addicts. The action and the drama and the pressures of the day are probably greater than practitioners give credence to. When all of that stops there is a void. Certainly students lead a very insular life. It finally did get to me after a while and this past year I went and took a part time job. I did it as much to get out and get some action as for the supplemental income. There isn't a lot of action sitting around a library reading cases that can date back as far as the 1500s. Your responsibilities go from being pretty heavy to just being responsible for getting your assignments done.

Q: Was it a relief in some ways, to give up all that action?

A: It was. One way I noticed that still surprises me is how dramatically better I felt when I slept. I was only on every fourth night and every fourth weekend. When I moved out here, after I'd been here for a month, I realized that I had never really felt that rested.

I'm forty-two. I think people in their thirties and forties often feel a need to scrutinize their lives. I think that it helps to conduct that kind of examination during a period of withdrawal. And that's the flavor that school has for me... kind of a sabbatical and retreat.

Q: Do your colleagues talk about doctors as a group? Do you find yourself defending doctors or participating in the criticism as a more knowledgeable observer? Is it just our narcissism that makes us speculate that they do? When lawyers talk about health care policy maybe they don't even mention doctors—they just say things like: "Health care has got to be socialized."

A: I just took a course in health care policy that was taught by someone who is younger than me; many

continued

An Interview with Brian Akers, M.D., Law Student continued

of the professors are. I was the only person in the room, when we talked about solving the problems of access and funding in health care, who was even willing to talk about nationalizing the health care system as a serious option. I'm considered to be the aged radical.

I'm constantly amazed at how much health care figures in the law in general. The class will be discussing aspects of criminal procedure or arcane aspects of property law and they'll wander into one of these medical areas and they'll call on me and I'll get in trouble for not paying attention. In general, lawyers that I meet here, with a few glaring exceptions, hold doctors in *too much* esteem. they expect more from physicians than I feel physicians have to give to the world. Lawyers may always seem to be there ready to make trouble for doctors. I think some lawyers may have very unrealistic expectations of what physicians are capable of and what their role really is. I raise my hand and say: "Well you know doctors don't do that" or, "Doctors can't do that" or, "Well you know *that's* illegal."

Q: Can you give me an example?

A: Informed consent. I did a research project last summer on it. It turns out that its actually a legal doctrine' it did *not* originate from medical ethics and medical practice. It sprang from litigation cases that date back to the 1700s in England. I'm sitting in health policy class and the professor gives a hypothetical of a young woman refusing to give permission for a blood transfusion in the first instance to save the life of her son; or in the second case refuses the transfusion for herself for religious reasons, even though her husband strongly objects; or in the third example refuses to allow an elderly person in her family who's dying of cancer to take the transfusion. Several of the people in the class stuck up their hand and said that the doctor is supposed to give the transfusion. It turns out there's a famous case from the petition of Georgetown Hospital in the early seventies. Judge Wright ordered a transfusion on a Jehovah's witness who had refused it. I was appalled. I had heard of the case, but I thought a law student would think that was right. When they turned to me for the "final word" during class, I had to say: "That's really wrong; that's assault. The patient really decides, except in the case of the child."

Q: What are your goals at this time in law?

A: I'm looking for a position in a corporate law firm that specializes in health law. There's a lot more to health law than medical malpractice.

Q: Have you applied for jobs already?

A: Oh, yes. Recruiters have been to Stanford to interview our class. there are about 140 students in my class (as compared to 700 at Harvard). One third of the members of my class have had jobs before coming to law school. I had 20 interviews and 9 "call backs" as they call them. I went on six interviews. This summer I will be working for a large firm in Milwaukee that does a lot of health care law. If everything goes well its assumed that I'll be offered a job there when I graduate.

Q: Do you feel that your age has worked against you?

A: Not at all. I feel I have done as well through the selection process as my classmates and that my age and experience are an asset.

Q: So what would you say is the most exciting thing about what you are doing right now? What advice would you give to fellow doctors who are fantasizing about starting new careers?

A: Medicine, in all its facets, is such an amazing preparation for other things in life. You don't realize it, because very few people take medicine as a stepping stone to anything. The people you meet and the skills you acquire have wide applicability. You yourself could go right now into so many other things and you don't know it because you have no way to test it. I think the most satisfying thing is to discover how life, especially a medical life, prepares a person for other forms of service.

Bridgid Glacken, M.D.
Co-Editor

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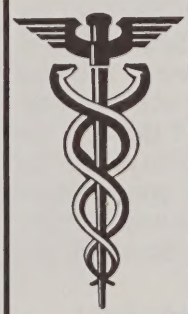

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Sharon K.J. Cathcard, D.O.
444 Montgomery Street
Chicopee, MA 01020

BORN:	January 14, 1958
PREMED:	St. Olaf College, Minnesota 1976-1980
MEDICAL:	Chicago College of Osteopathic Medicine 1980-1984
INTERNSHIP:	Doctor's Hospital, Ohio 1984-1985
RESIDENCY:	Doctor's Hosptial, Ohio 1985-1989
SPECIALTY:	Obstetrics/Gynecology

Torben B. Iversen, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN:	August 22, 1957
PREMED:	Ulster County Community College, New York 1/83-7/83 SUNY at Stonybrook, New York 1983-1985
MEDICAL:	SUNY at Buffalo, New York 1985-1988
INTERNSHIP:	Baystate Medical Center 1988-6/89
RESIDENCY:	Baystate Medical Center, 7/89-Present
SPECIALTY:	Obstetrics/Gynecology RESIDENT

Ezzat S. Mankarious, M.D.
Medical Care Center
P.O. Box 707
East Longmeadow, MA 01028

BORN:	September 21, 1930
PREMED:	College of Science, Cairo University, Egypt 1947-1948
MEDICAL:	KASR El Aini Faculty Medicine, Cairo University 1948-1954
INTERNSHIP:	National Egyptian Hosptials in Upper Egypt 1954-1955
RESIDENCY:	NHS National Health Service Hospitals, U.K. 1973-1975
FELLOWSHIP:	Registar University Hospital of Wales Cardiff and Plymouth General Hospital 1976-1977
SPECIALTY:	Family Practice/Internal Medicine

continued

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Welcome New Members

continued from previous page

Virginia L. Walters, M.D.
305 Bicentennial Highway
Springfield, MA 01118

BORN: October 10, 1953
PREMED: University of Delaware 1971-1975
MEDICAL: College of Medicine & Dentistry of New Jersey 1975-1977
Jefferson Medical College, Pennsylvania 1977-1979
INTERNSHIP: Willmington Medical Center, Delaware 1979-1980
RESIDENCY: Wilmington Medical Center, Delaware 1980-1983
SPECIALTY: Obstetrics/Gynecology

Robert E. Shepherd, M.D.
1295 State Street
Springfield, MA 01111

BORN: July 9, 1947
PREMED: University of Nevada 1965-1969
MEDICAL: University of Colorado Medical School 1969-1973
INTERNSHIP: University of Kentucky 1973-1974
RESIDENCY: University of Kentucky 1974-1976
SPECIALTY: Insurance Medicine (Administrative)/ Internal Medicine

Barry L. Smith, D.O.
305 Bicentennial Highway
Springfield, MA 01118

BORN: May 2, 1950
PREMED: University of Delaware 1969-1972
University of Delaware Graduate School 1974-1975
MEDICAL: Philadelphia College of Osteopathic Medicine 1975-1979
INTERNSHIP: Tri County Hospital, Pennsylvania 1979-1980
RESIDENCY: Wilmington Medical Center, Delaware 1980-1983
SPECIALTY: Internal Medicine

Gary S. Reiter, M.D.
15 Hospital Drive, Suite 403
Holyoke, MA 01040

BORN: May 28, 1955
PREMED: University of California, Berkeley 1973-1977
MEDICAL: University of California, Davis 1978-1982
INTERNSHIP: Pacific Medical Center, San Francisco 1982-1983
RESIDENCY: Pacific Medical Center, San Francisco 1983-1985
SPECIALTY: Internal Medicine

Jan O. Johansson, M.D.
Mercy Hospital Rehabilitation
233 Carew Street
Springfield, MA 01104

BORN: November 3, 1944
PREMED: University of Lund, Sweden 1965-1973
University of California, 1972-1973
MEDICAL: Karolinska Institute, Stockholm, Sweden 1975-1980
INTERNSHIP: Long Island College of Medicine 1985-1986
RESIDENCY: Albert Einstein College of Medicine 1986-1989
SPECIALTY: Physical Medicine & Rehabilitation

John M. Roberts, M.D.
Shriner's Hospital
516 Carew Street
Springfield, MA 01104

BORN: February 27, 1932
PREMED: Yale University 1949-1953
MEDICAL: Columbia University College of Physicians and Surgeons, New York 1953-1957
INTERNSHIP: Duke University Medical Center 1957-1958
RESIDENCY: Duke University Medical Center 1958-1963
FELLOWSHIP: Duke University Medical Center 1961-1962
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Excerpts of MMS Executive Briefs

Retention Period for Medical Records.

New Board of Registration in Medicine (BRM) regulations require (in most cases) that physicians retain patient medical records (that exist on or after Jan. 1, 1990) for a minimum of seven years. This is an increase from the previous retention period of three years.

The BRM regulations require physicians to retain all patient medical records existing on or after January 1, 1990 in a manner which permits former patients and successor physicians to access them for a minimum period of seven years from the date of the last patient encounter. In cases of minor patients under the age of two, the same holds true until patients reach the age of nine. According to the BRM newsletter issued in the summer of 1987, the "last patient encounter" may be only a telephone or mail contact between physician and patient.

In the case of a retiring physician, the physician's successor or the estate of the deceased physician, the BRM's regulations require retention of patient medical records existing on or after January 1, 1990 in a manner which permits former patients and their successor physicians to access them for a minimum of seven years, or, in the case of a minor patient under two, until the child reaches the age of nine.

These BRM regulations are set out at 243 CMR 2.07(7) and (13). Copies of the new regulations may be obtained by writing to the Society's Legal Services Department at Massachusetts Medical Society Headquarters. ■

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